EXPERT DECLARATION ALEJANDRA ACUÑA

I, Alejandra Acuña, hereby declare as follows:

1. I am a licensed clinical social worker, accredited by the state of California. I am currently an Assistant Professor in the Department of Social Work at California State University, Northridge.

2. I earned my Ph.D. in Social Welfare from University of California, Los Angeles, in 2015. I also hold a Master's degree in Social Welfare from University of California, Berkeley. I have over 20 years of experience as a clinical social worker and have provided the full range of clinical services, which consists of client engagement, bio-psycho-social-spiritual assessment, diagnosis, treatment planning, clinical interventions and case management, progress monitoring, evaluation, and termination. I have worked with children and families in child protective services systems, non-profit community-based organizations, and public-school districts. Most of my clients have been from low-income, ethnic minority, and/or immigrant communities (including unaccompanied minors), and have experienced domestic and community violence, deportation, incarceration, and other traumatic events. In 2001, I conducted a psychological assessment and provided expert testimony in a deportation proceeding. In the last year, I have completed three psychological assessments for asylum proceedings with three more underway this summer.

3. Attached hereto as Exhibit A is my Curriculum Vitae.

4. My declaration is based on my education, clinical and research experience, as well as a review of scientific literature. Attached as Exhibit B is a list of references to research relied on in support of my declaration.

5. On July 5, 2018, I conducted an evaluation of J. P. at the James A. Musick Facility in Irvine, CA. J.P. is a 37-year-old woman from Guatemala who came to the United States with her adolescent daughter, L.P., in May 2018. I understand from my meeting with J.P., that she was forcibly separated from her daughter by U.S. immigration authorities shortly after arriving in the United States.

6. J.P. reports that she was terrified by the fact of separation and thought that she would never see her daughter again. J.P. told me that no one explained to her what was happening. J.P. reports that when her daughter, L.P., was told about the separation, L.P. began to sob, was frightened, fainted, and fell to the ground hitting her face, causing injury with bleeding.

7. It is my professional opinion that J.P. is displaying symptoms of post-traumatic stress disorder (PTSD) as a result of her separation from her daughter. J.P. reports having upsetting thoughts or images about being separated from her daughter "almost always." She reports having bad dreams and nightmares "half the time." She reports feeling upset when she thinks or hears about events that have transpired "almost always" and reports crying four times a day. She reports having feelings in her body when she thinks about or hears about being separated from her daughter "almost always." J.P. became visibly tearful when speaking about her daughter. J.P. also reports feeling as if her future plans will not come true "half the time." She reports having trouble falling or staying asleep "almost always" and waking up three times in the middle of the night. J.P. reports being tired a lot (compared to the energy she had in Guatemala). She also reports having trouble concentrating "almost always."

8. It is also my professional opinion that J.P. is displaying symptoms of both depression and anxiety. J.P. reports feeling nervous, anxious, unable to control worrying, and feeling afraid that something awful will happen nearly every day. She reports that when she sees women leave the detention center, she does not know where they go and what happens to them. She worries what will happen to her next. She also reported feeling down, depressed or hopeless, having trouble falling asleep, and feeling tired or having little energy nearly every day.

9. J.P. told me that she wishes she could talk to someone about what is going on and the "sadness she feels in her whole body," but there is no one at the facility who speaks her language. I have interviewed other women at Musick Detention Center and they have not reported having access to mental health treatment.

10. It is my experience that some families who have been detained, have suffered trauma in their countries of origin, as well as on their journey. Where parents and children are already vulnerable, the practice of separating parents from children causes further harm to both parents and children.

11. If left untreated, it is my opinion that the symptoms that J.P. has reported could escalate into a diagnosis of PTSD, Dissociative Disorder, and Major Depressive Disorder. PTSD can further escalate into more severe mental health and social problems. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013), these problems can include (1) intrusive recollections of the event (sensory, emotional, or physiological behavioral components); (2) dissociative states (from a few seconds to several hours or even days); (3) negative alterations in cognitions or mood (begin or worsen after exposure to the traumatic event). Additionally, individuals with PTSD may be quick tempered, engage in aggressive verbal and/or physical behavior, or may engage in reckless or self-destructive behavior. Some individuals experience persistent dissociative symptoms of detachment from their bodies (depersonalization) or the world around them (derealization). Developmental regression, such as a loss of language in young children, may occur. Auditory pseudo-hallucinations and paranoid ideation can also occur. Following prolonged, repeated, and severe traumatic events, individuals may experience difficulties in regulating emotions or maintaining stable interpersonal relationships, or dissociative symptoms. Further, traumatic events increase a person's risk for suicide. PTSD is associated with suicidal ideation and attempts (APA, 2013). There are also functional consequences of PTSD. PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains (APA, 2013).

12. It is also my opinion that J.P.'s daughter, who is separated from her mother and currently detained, is at risk of mental health problems as a result of separation. For youth specifically, multiple exposures to stressful conditions puts them at increased risk for developing mental health problems, such as PTSD symptoms (Aisenberg & Herrenkohl, 2008; Lambert, 2010), depression and anxiety (Gopalan, 2010). Similar to other conditions seen in childhood, about 75% of those youth with PTSD have a co-occurring condition such as depression, another anxiety disorder, substance abuse, dissociation, increased suicidal thoughts and behaviors or conduct problems (Aisenberg & Herrenkohl, 2008). Additionally, traumatized children are more likely to be involved in violent relationships, either as victims or perpetrators (Gopalan et al., 2010). Further, ongoing exposure to traumatic events may disrupt cognitive development (Cooley-Strickland et al., 2009), including decreased IQ and be related to decreased academic functioning (Aisenberg & Herrenkohl, 2008) and decreased rates of high school graduation (Stein et al., 2003). Finally, youth need more support than adults because they are less skilled at expressing their trauma-related concerns and have fewer informal and formal sources of support and psychological coping (Cooley-Strickland et al., 2009).

13. As a result, I believe that there is a substantial risk of imminent harm for J.P. and any other detainees who remain untreated. Based on my experience, it is my professional opinion that the trauma of family separation places individuals at a high

risk for PTSD or other trauma-based disorders. It is imperative that all parents and children who are similarly situated to J.P. and her daughter be screened for symptoms of trauma, including but not limited to PTSD, depression, and anxiety. Researchers documented various ways that children expressed reactions to their parents leaving, including anger, distress, feelings of vulnerability, abandonment, and somatic complaints (Shapiro et al, 2013). One study found that children separated from their parents due to immigration were more likely to report depressive symptoms than children who had not been separated (Suarez-Orozco, 2002). Another study examining the impact of trauma exposure and immigrant stressors on psychopathology among urban Latino youth found acculturative stress positively associated with psychopathology, separation from either parent associated with externalizing symptoms and PTSD, and lifetime violence exposure strongly related to all forms of psychopathology (Gudino, Nadeem, Kataoka & Lao, 2011). A large, longitudinal study measured three types of separation (not due to death): maternal, paternal, and from both parents, across the ages of 1–15 years (N=985,058). Each type of separation was positively associated with both schizophrenia and bipolar disorder (Paksarian, Eaton, Mortensen, Merikangas & Pederson, 2015).

11. Following screening, any parents or children displaying symptoms of trauma should be provided with immediate treatment. Any delay in providing screening and/or treatment may risk exacerbating the consequences of trauma, and may cause

permanent harm. Children exposed to trauma can experience a number of short-term and long-term disturbances in self-regulation (e.g., avoidance, withdrawal, sleep disturbance, changes in appetite, difficulties regulating mood, and difficulties concentrating, exaggerated startle response, hyper-vigilance, a need to repeat the event through words and/or play, flashbacks or re-experiencing), somatic complaints (e.g., headaches, stomachaches, and back pain), as well as increased disturbances in mood, developmental achievements, behavior and risk-taking activities (e.g., using drugs and alcohol, promiscuous sexual activity, skipping school, running away from home). If symptoms do not subside over time on their own or with treatment, individuals may develop depression, anxiety, PTSD, personality changes, substance abuse, and impaired school functioning. Additionally, traumatized children are more likely to be involved in violent relationships, either as victims or perpetrators (Gopalan et al., 2010, p. 189). Mexican and Central Americans may be exposed to stress before, during, and after migration (Torres et al., 2018). A growing body of research on the psychosocial impact of forced migration documents the refugee experience as a chronic process of traumatization. The complex cluster of pre-flight and post-flight stressors of war, violent loss, persecution, ethnic conflict, family separation, cultural uprooting, acculturation stressors and legal insecurity forms a pervasive cumulation of life-threatening events and multiple losses and, thus, identifies the refugee experience as a long-term adverse context (Lustig et al., 2004 in Haene, Grietens & Verschueren, 2010).

There is a significant positive relationship between multiple adverse events and poor outcomes; as the number of adverse events increases – even two or more – health and mental health-related outcomes worsen (CAMHI, 2014). Given the number of stressors that families and children face, access to care becomes even more important.

12. Appropriate treatment for trauma caused by separation should consist of family therapy, which includes all family members and is necessary to address family pain. Treatment should ideally be provided outside of detention as symptom recurrence and intensification may occur in response to reminders of the original trauma, ongoing life stressors, or newly experienced traumatic events (APA, 2013).

13. Attachment theory demonstrates the urgency of providing therapy in the family environment. John Bowlby developed attachment theory by studying the behaviors of normal infants and children who had experienced temporary separations from and reunifications with their parents, in order to make generalizations about their mourning behaviors. Bowlby described attachment as a homeostatic control mechanism that is preferentially responsive to a small number of familial caregivers, maintaining the relationship with the attachment figure within certain limits of distance and accessibility. He asserted that the infant's response to potentially fearful situations was partly dependent on predictions of how available the attachment figures were going to be. He also felt that patterns of attachment became stable over time and could be transmitted intergenerationally. Confusion, helplessness and displaced rage of children

after parent-child separation is a normal reaction (Shapiro et al, 2013). The child must maintain proximity to, contact with, or availability to the significant person because distress will likely be experienced at involuntary separation. To ensure safety and security, close physical proximity to the attachment figure is the set goal of the attachment system for very young children. This attachment behavioral system is important for infants, toddlers, and school-age children in that they are still not competent to make decisions completely on their own regarding their activities, supervision, or protection (Kuehnle & Ellis, 2002).

14. A 2001 study demonstrates that parental attachment is critical to recovery from trauma. In a study with children hospitalized for treatment of severe burns, the development of PTSD could be predicted by how safe they felt with their mothers (Saxe, 2001). The security of attachment to their mothers predicted the amount of morphine that was required to control their pain – the more secure the attachment, the less painkiller needed. In another study with New York City children who had directly witnessed the terrorist attacks on 9/11, children whose mothers were diagnosed with PTSD or depression during follow-up were six times more likely to have significant emotional problems and eleven times more likely to be hyper-aggressive in response to their experience (Chemtob et al., 2008). While parents need all the help they can get to help raise secure children, traumatized parents, in particular, need help to be attuned to their children's needs. Parents who are preoccupied with their own trauma, such as

domestic abuse or rape may be too emotionally unstable and inconsistent to offer much comfort and protection, which may lead to disorganized attachment. Children with disorganized attachment are at high risk of developing a range of psychiatric problems and show more physiological stress, as expressed in heart rate, stress hormone responses, and lowered immune factors (Hertsgaard et al., 1995). Children whose parents are reliable sources of comfort and strength have a lifetime advantage – a kind of buffer against the worst that fate can hand them (van der Kolk, 2014). So mental health treatment for parents is important for both generations.

15. Some practitioners and researchers have called the Latino family the 'great untapped resource since it is a natural support system that promotes health, psychological growth and protection against stressors. This is supported by literature that points out many research-based protective factors that prevent development of PTSD after trauma exposure, including parenting, good parental mental health, and good child somatic health history (Qouta, Punamäki & Sarraj, 2008); highly functioning parents and good family relations (e.g., communication, bonding and warmth) (Cooley-Strickland et al., 2009). There is good reason to believe that parents influence the development of behavior in children that may be involved in moderating the impact of stress (Masten, 2001).

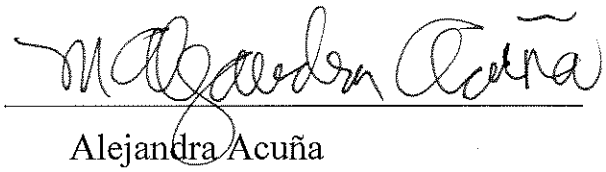
16. Two approaches for the treatment of PTSD treatment among children and adolescents have shown substantial evidence of effectiveness - Cognitive Behavioral

Intervention for Trauma in Schools (CBITS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - have common elements, including: 1) *Psychoeducation* about PTSD, anxiety, and the prevalence and impact of trauma; 2) *Relaxation and Affective Modulation Skills for* managing physiological and emotional stress; 3) *Exposure or Gradual Desensitization* to memories of the traumatic event and to innocuous reminders of the traumatic event, 4) *Cognitive Restructuring* of inaccurate or maladaptive/unhelpful cognitions, and 5) Parenting, parent-child sessions, and parent sessions. In addition to these common clinical elements, CBT treatment approaches to PTSD also include common delivery components, including and assignment of weekly practice of skills in real-world settings (e.g., home, school), to occur in between sessions. Salient themes that may facilitate resilience: 1) individual coping along with adaptive family functioning; 2) prayer, belief in God, and church services can be adaptive sources of coping; 3) a strong sense of ethnic identity (i.e., a sense of pride in or positive feelings about one's ethnicity and culture; 4) familism, reflecting the values of family solidarity, family support, and an enduring commitment to family members, where one often places the needs of one's family above the individual, has been deemed an important Latino/a cultural value and may buffer the impact of migration-related stressors while family cohesion may be a source of support in the face of immigration stress (Dorsey, Briggs & Woods, 2011).

17. The practice of separating parents from children causes harm to both parents and children, who are already vulnerable from traumatic events before, during, and after their immigration to the US. It is well-established that there is a dose-response relationship between traumatic events and negative physical/mental health outcomes, so it is imperative that further harm is not done and that harm done is addressed. Mental health screening and family-based and effective treatment in a community setting must be provided to parents and children who experienced separation in detention.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on July 10, 2018, at Los Angeles, CA.



Alejandra Acuña

Exhibit A

Curriculum Vitae

M. ALEJANDRA ACUÑA, Ph.D. MSW, LCSW, PPSC
aacuna@csun.edu

ACADEMIC APPOINTMENTS

2015-	**Assistant Professor**, *California State University, Northridge;* Department of Social Work
2014-15	**Lecturer**, *California State University, Northridge;* Department of Social Work
2014-15	**Lecturer**, *California State University, Los Angeles*; Department of Child and Family Studies, Department of Chicana/o and Latina/o Studies
2001-14	**Lecturer**, *California State University, Los Angeles*; School of Social Work

EDUCATION, LICENSING & CREDENTIALS

2015	**Ph.D., Social Welfare**, *University of California, Los Angeles*
2007	**Licensed Clinical Social Worker (LCSW),** *California Board of Behavioral Sciences*
1996	**Master of Social Welfare (MSW),** *University of California, Berkeley;* Concentration: Children, Youth & Families
1996	**Pupil Personnel Services Credential (PPSC),** *California Commission on Teacher Credentialing;* Specialization: School Social Work; Child Welfare and Attendance
1989	**B.A., Biology,** *Vanguard University*

PEER-REVIEWED PUBLICATION

Acuña, A. & Kataoka, S. (2017). Family Communication Styles and Resilience among Adolescents. *Social Work*, *62*(3), 261-9.

IN PRESS

Acuña, M.A., & Martinez, J.I. (in press). Pilot Evaluation of Back to Basics Parenting Training in Urban Schools. *School Social Work Journal.*

Kataoka, S., Vona, P., **Acuna, M.A**., Jaycox, L., Escudero, P., Rojas, C., Ramirez, E., Langley, A., & Stein, B.D. (in press) Applying a Trauma Informed School Systems Approach: Examples from School Community-Academic Partnerships. *Ethnicity & Disease*.

BOOK CHAPTERS

Acuña, A., Martinez, S., & Warren, B. (1994). Youth and HIV Testing. In M. Quackenbush & K. Clark (Ed.), *The AIDS Challenge: Prevention Education for Young People*. Santa Cruz: ETR Associates.

Acuña, A. (1992). The Smokeless Vision Network. In *Live It Up: Supporting a Tobacco-Free Lifestyle*. NorthBay Health Resources Center.

NON-PEER REVIEWED PUBLICATIONS

Acuña. A. & Escudero, P. (2015). Helping those who come here alone. *Phi Delta Kappan, 97,* 42-45.

Acuña, A. (1996, April). The Child Welfare Worker as Advocate, Part 2. *National Association of Social Workers (NASW) California News, 22(6)*, 6.

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Acuña, A. (1995, December). Latin American Immigrants. *FOCUS: A Guide to AIDS Research and Counseling, FOCUS Supplement on HIV Antibody Test Counseling, 11*(1), 1-3.

Acuña, A. (1994, Fall). The Importance of Youth Sensitivity. *FYI: For Youth Information, Newsletter of the Los Angeles County AIDS Programs Adolescent HIV Prevention Project, 2*(2), 3.

SELECTED CONFERENCES & PRESENTATIONS

Minority Male Mentoring: A Multi-Tiered Model for College Success, National Symposium on Student Retention (NSSR), *Florida, 2017.*

Family Communication Styles, Stressful Events, PTSD and Resilience, Latino Social Worker Organization Conference, Berkeley, 2017.

Evidence-Based Support for Culturally Diverse Students Rising above Trauma: Models for Building Multidisciplinary Workforce, Scaling up Implementation, and Incorporating Youth Voices of Resiliency, The 16th Annual Conference on Advancing School Mental Health, South Carolina, 2011.

Cognitive Behavior Intervention for Trauma in Schools (CBITS), Training for 100 Department of Mental Health sub-contractors, Pasadena, 2010.

Connecting School Social Work Practice to Mental Health and Academic Outcomes, California School Social Work Conference, Oakland, 2008.

The South Los Angeles Resiliency Project: Outcome Evaluation Methods and Results, School Social Work Association of America Conference, Denver, 2008.

Back in Control®: How to get your kids to do what they are supposed to do and *Lessons Learned from Developing the School Team Enhancement Project*, School Social Work Association of America Conference, Boston, 2006.

HONORS & AWARDS

2009	Friends of School Mental Health Marion McCammond Social Work Award
2004	Heart of Social Work Field Instructor Award - North American Field Educators and Directors
2003	Clinical Instructor appointment, UCLA Department of Social Welfare
2003	Field Instructor, Special Recognition Award, CSULA School of Social Work
2000	Outstanding Field Instructor Award, CSULA School of Social Work
1996	Ryan White's Angel Award for innovative peer education and counseling program, Project ABLE – Los Angeles Free Clinic

SOCIAL WORK PRACTICE EXPERIENCE

2014-	**Professional Expert,** Los Angeles Unified School District (LAUSD)
2014-16	**Clinical Consultant,** Plaza Community Services
2013-14	**Clinical Supervisor**, People Assisting the Homeless (PATH)
2013-14	**MSW Intern Supervisor**, Glendale Unified School District (GUSD)
2012-13	**Clinical Director,** El Nido Family Centers
1998-2011	**Psychiatric Social Worker (PSW)**, Los Angeles Unified School District
1997-98	**Neighborhood Outreach Coordinator**, Pico Rivera City Hall
1996-97	**Social Worker**, Sonoma County Family & Children's Services
1993-97	**HIV Pre/Post-test Counseling Trainer,** State Office of AIDS
1995-96	**MSW Intern**, Bahia Vista Family Center, San Rafael City Schools
1994-95	**MSW Intern,** San Francisco Department of Social Services
1992-94	**Adolescent Outreach and Education Program Administrator**, Los Angeles Free Clinic
1990-92	**HIV Services Director,** Northeast Valley Health Corporation
1989-90	**Health Educator,** Northeast Valley Health Corporation

SPECIAL SKILLS

Languages: Fluent in Spanish; conversant in French

Exhibit B

References

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